Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 5, 2017

Ms. Brenda Egbert, Manager
Bradford Oasis
92 Cottage Street
Bradford, VT 05033-8897

Dear Ms. Egbert:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 24, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	R-C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD OASIS	92 COTTAGE STREET BRADFORD, VT 05033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R100}	Initial Comments: A follow up survey was completed by the Division of Licensing and Protection on 05/24/17 subsequent to the complaint survey of 01/09/17. The following regulatory violations were not corrected, and the new findings are stated below.	{R100}	Please see attached plan of correction.	
{R128} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that admission orders were obtained from a new primary care provider upon the first visit to the physician for 1 applicable resident in the sample. (Resident #1). Findings include: Per record review, Resident #1 was admitted to the facility from the hospital with transfer orders that were not ordered nor approved by the new Primary Care Provider (PCP) as of the day of survey. The resident was admitted on a Friday and had an appointment with a new PCP on the following Monday to set up admission orders for medications and treatments for living in the facility. The facility failed to assure that orders for admission to the facility were provided by the primary care physician and there was no evidence of any attempts to obtain the required admission orders in the medical record. Per interview, the Administrator/RN confirmed the	{R128}		

R128 - R173 POC's accepted 6/30/17 MBolton RN/me

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{R128}	Continued From page 1 lack of admission order from the PCP as of the date of survey, 5/24/17. The RN showed the surveyor a written visit summary from the PCP that included a list of medications that did not match the resident's current medications the resident was taking (per the Medication Administration Record/MAR). The facility's failure to obtain admission orders from the PCP upon a resident's admission continues to be uncorrected from the original survey citation on 1/9/17.	{R128}		
{R150} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility RN failed to document a resident's condition related to a fall with a head injury. Additionally, there was no follow up documentation in the record to reflect the health status of the resident upon return to the facility. (Resident #2). Findings include: Per staff interview and record review, Resident #2 was found on the floor in their room near the end of March, 2017. Per review of staff's incident report, the resident had a visible head injury and called the facility's on call RN (Registered Nurse) to report the fall with injury. Staff documented on the incident report that the nurse came in to the facility to see the resident and that the resident	{R150}		

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{R150}	Continued From page 2 was "sent out 911" to the ED (Emergency Department) via EMT's response to the 911 call on 3/24/27. Per review of the medical record, there was no documentation of the RN's assessment of the resident and no progress note that addressed the fall with head injury incident. The next RN progress note was written in the medical record on 3/29/17 (by another RN) and made no reference to the fall and treatment and follow up information of the resident's current condition. There was no evidence that the resident's post fall needs were met by the facility.	{R150}		
{R169} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.e Staff responsible for assisting residents with medications must receive training in the following areas before assisting with any medications from the licensed nurse: (1) The basis for determining "assistance" versus "administration". (2) The resident's right to direct the resident's own care, including the right to refuse medications. (3) Proper techniques for assisting with medications, including hand washing and checking the medication for the right resident, medication, dose, time, route. (4) Signs, symptoms and likely side effects to be aware of for any medication a resident receives. (5) The home's policies and procedures for assistance with medications.	{R169}		

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{R169}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility Registered Nurse failed to ensure that unlicensed staff were trained in the proper techniques for assisting with medications, to include hand washing, checking the medication for the right resident, medication, dose, time and route for 1 observed medication pass. Findings include: Per observation on 5/24/17 at 10:30 AM the Medication Technician (Med Tech) was observed removing medications from Bubble Packs (medication packaging provided by the pharmacy) directly to his/her gloved hands and placed each pill into a souffle cup. S/he proceeded, handling approximately 12-14 packs of various prescription and over the counter medications without changing his/her gloves or washing his/her hands. The med tech failed to compare the directions on the Bubble Packs to the Medication Administration Record (MAR) that identifies the physician's orders. Per interview with the Med Tech after the medication administration, confirmation was made that she did not compare the medications to the MAR nor was she aware that she could not handle each tablet. Per "Medication Administration Examination", the Med Tech identified the "Steps of administering medications as: 1) Hand Washing; 2) Check MAR; 3) Check Bubble Pack against MAR; 4) Administer Medications; and 5) sign off medication when given". Question #24 asks "True or False: It's all right to handle a resident's medications with your hands while you are dispensing as long as you have	{R169}		

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{R169}	Continued From page 4 taken the proper sanitation precautions such as: washing your hands." The Med Techs response was "False" which is the correct response.	{R169}		
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all medications were stored in locked compartments related to an unlocked and unattended medication cart. Findings include: Upon entrance to the facility to conduct a survey on the morning of 5/24/17, an unlocked and unattended medication cart was observed in the entrance hallway, where it is usually stored. There were no staff within sight of the medication cart, creating a risk of possible access by unauthorized personnel. The observation of the unlocked medication cart was confirmed with the staff person on duty at the time.	R173		

BRADFORD OASIS

PLAN OF CORRECTION

JUNE 29, 2017

R128. 5.5c

Hospital discharge orders are appropriate for admission to residential care. Regulations do not stipulate PCP orders.

Her discharge orders contained all the information required for residential care admission as well as a follow up clinic appt.

The 6/22/17 and subsequent visits have been made with the local clinic. The resident is being seen by this clinic MD until she is established with her new clinic and PCP. The process of obtaining a new PCP has been started.

The resident's MAR and the clinic summary did not match because new meds/doses had not yet arrived and the MAR could not yet be changed. It was discovered the scripts had been sent to the wrong pharmacy despite clear information given to MD. Meds arrived the evening of 5/24/2017.

MAR and med orders now coincide. Meds are being administered per orders.

RN/ADM will oversee admissions and meds. We will clearly emphasize contact info for the appropriate pharmacy. We will contact pharmacy asap to learn if orders were received. We will follow up any issues immediately. Completed 5/29/2017.

R150 5.9C

The resident was initially assessed and sent for ED evaluation. It was determined at the ED that she had no concussion or other head injury. Head laceration was bandaged and she returned to the residence. There was no comprehensive follow up of this small laceration. We have instituted a more detailed process of documentation.

RN/ADM will oversee future incident management. Completed 6/10/2017

R69 5.10E → R173 5.10.h

This deficiency demonstrates a staff member lapse of procedure. Staff who administer medications are not med techs which is a trained and licensed position. They are, however, trained by RN staff in med administration. This event was not due to inadequate training. The staff member knows full well that comparison of med and MAR is required. This is clearly a breach of protocol. The exam question #24 refers to bare hands, not gloved hands. Proper med administration has been reviewed and emphasized to this staff member. Gloves are not to be worn or pills put in gloved hands. Subsequent observations have shown proper technique of comparing meds with MAR.

It is regulation and policy that the med cart is never left unlocked. The staff went to answer an urgent resident call and neglected to shut the cart.

The staff member has been reprimanded, re-educated in med procedures and observed passing meds 6 times since this incident. All observations have been appropriate.

Med procedures were reviewed and emphasized at June 14 staff meeting.

RN/ADM will oversee med education and staff performance. Completed 6/15/2017.

Brenda Eckert, mgr
6/29/17